number(s), and the case number(s) (if assigned), for such appeal(s).

(c) *Adding issues to the hearing request.* After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:

(1) The request to add issues complies with the requirements of paragraphs (a)(1) and (b) of this section as to each new issue.

(2) The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) of this section.

(3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section.

[73 FR 30249, May 23, 2008; 73 FR 49356, Aug. 21, 2008]

§ 405.1836 Good cause extension of time limit for requesting a Board hearing.

(a) A request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in § 405.1835(a)(3) of this subpart must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.

(b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).

(c) The Board may not grant a request for an extension under this section if—

(1) The provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request; or

(2) The date of receipt by the Board of the provider's extension request is later than 3 years after the date of the intermediary or other determination that the provider seeks to appeal.

(d) If an extension request is granted or denied under this section, the Board must give prompt written notice to the provider, and mail a copy of the notice to each party to the appeal. The notice must include a detailed explanation of the reasons for the decision by the Board and the facts underlying the decision.

(e)(1) If the Board denies an extension request and determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a Board dismissal decision dismissing the appeal for lack of Board jurisdiction. This decision by the Board must be in writing and include the explanation of the extension request denial required under paragraph (d) of this section, in addition to specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal (as described in § 405.1840(c) of this subpart). A copy of the Board's dismissal decision must be mailed promptly to each party to the appeal (as described in § 405.1843 of this subpart).

(2) A Board dismissal decision under paragraph (e)(1) of this section is final and binding on the parties, unless the decision is reversed, affirmed, modified, or remanded by the Administrator under §§ 405.1875(a)(2)(ii) and 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision.

(i) This Board decision is inoperative during the 60-day period for review of the decision by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands that decision, within the period.

(ii) A Board decision under paragraph (e)(1) of this section that is otherwise final and binding may be reopened and revised by the Board in accordance with §§ 405.1885 through 405.1889 of this subpart.

(3) The Administrator may review a Board decision granting an extension request solely during the course of an Administrator review of one of the Board decisions specified as final, or deemed final by the Administrator, under § 405.1875(a)(2) of this subpart.

(4) A finding by the Board or the Administrator that the provider did or did not demonstrate good cause for extending the time for requesting a Board hearing is not subject to judicial review.

[73 FR 30250, May 23, 2008; 73 FR 49356, Aug. 21, 2008]

§ 405.1837 Group appeals.

(a) *Right to Board hearing as part of a group appeal; criteria.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period, only if—

(1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a), except for the $10,000 amount in controversy requirement under § 405.1835(a)(2) of this subpart;

(2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and

(3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with § 405.1839 of this subpart.

(b) *Usage and filing of group appeals*—(1) *Mandatory use of group appeals.* (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

(ii) One or more of the providers under common ownership or control may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for purposes of meeting the $50,000 amount in controversy requirement, and, subject to the Board's discretion, may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for other purposes, such as convenience.

(iii) A group appeal involving two or more providers under common ownership or control must consist entirely of providers under common (to all) ownership or control.

(iv)(A) Example 1: A, B, C and D are commonly owned providers that wish to appeal issue X. This issue was adjusted on A, B and C's CY 2004 cost reports, and on D's CY 2005 cost report. The amount in controversy is more than $50,000 in the aggregate for providers A, B and C, and more than $10,000 for provider D. Providers A, B and C must appeal issue X as a group appeal. Provider D may pursue an individual appeal to the Board under the procedures set forth in § 405.1835 of this subpart, or if the Board agrees, Provider D may join the group appeal. (If Provider D joins the group appeal, the calendar years in the group appeal would then be 2004 and 2005, and any provider related to Providers A through D by common ownership or control would be required to appeal issue X for its cost reporting period ending in 2004 or 2005 through the group appeal.)

(B) Example 2: A, B and C are commonly owned providers that wish to appeal issue X. This issue was adjusted on A, B and C's CY 2004 cost reports. The amount in controversy is less than $50,000 in the aggregate for providers A, B and C ($10,000 for A, $10,000 for B and $7,000 for C). Providers A, B and C cannot appeal issue X as a group appeal. Provider A, if it wishes, and provider B, if it wishes, may pursue an individual appeal to the Board under the procedures set forth in § 405.1835 of this subpart. Provider C may not pursue an individual appeal to the Board, because the amount in controversy is less than $10,000; however, it may pursue an appeal to the intermediary under the procedures set forth in § 405.1811 of this subpart.

(2) *Optional group appeals.* (i) Two or more providers not under common